TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Stephenville

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-18-0151-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
September 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim denied for untimely filing. Contact was made to the patient several time in hopes of receiving updated WC information. Contact was finally made with the employer who gave updated WC information. Please re-review the bill and medical records and reconsider your decision for untimely."

Amount in Dispute: $1,043.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After full review of the dispute packet submitted by the requestor Texas Health, the Office has determined we will maintain our denial for 29-Time limit for filing for dates of service 8/29/2016 as the provider has failed to submit sufficient evidence to support that the bill was submitted to the carrier in accordance with 28 TAC §133.20 and/or Texas Labor Code §408.0272."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2016	320/71010, 450/99285 25	$1,043.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission by health care providers.
3. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.

4. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the request for MFDR timely?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered on August 29, 2016 in the amount of $1, 043.28.

   The insurance carrier denied disputed services with claim adjustment reason code 29 – The time limit for filing has expired. 28 Texas Administrative Code §133.20 (b) states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

   The Division reviewed the following documentation submitted with this request for medical fee dispute:

   - UB-04 CMS 1450 with creation date of March 7, 2017
   - Explanation of remittance that indicates, "Carrier Rcvd Date: 03/10/2017."

   Texas Labor Code §408.0272 (b) provides certain exceptions to the 95-day time limit for bill submission:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   >
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   >
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   >
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   >
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
   >
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   Based on our review no documentation was found to support an exception described in Texas Labor Code 408.0272 (b) exists. Therefore, the requestor was required to submit the medical bill within 95 days from the date of service. The carrier's denial is supported. No additional payment is recommended.

2. 28 Texas Administrative Code §133.307 (c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.

   (1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of service in dispute is October 29, 2016. The date the request for MFDR was received was September 18, 2017. This date is greater than one year from the date of service. As insufficient evidence was found to support an exception detailed in 28 Texas Administrative Code (c) (1) exists, this request for MFDR was not submitted timely.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.